



Columbia  
County CSP

**Referral Form**

Send to: Dawn Anderson-Mueller  
1440 E. Wisconsin Street  
Portage, WI. 53901  
(608) 745-9292 Fax: (608) 745-9293

The following information will be kept confidential and will be used to help determine whether the person being referred is appropriate for CSP services at Journey Mental Health Center CSP-Columbia County. The CSP Team Leader or designee will respond within 48 business hours of receiving the application. The Team Lead or designee may request additional information needed to make a final determination for eligibility for CSP service.

All referrals must include a signed Release of Information between the referring agency/family member and Journey Mental Health Center- Columbia County CSP. Include copies of 6 months to a year of psychiatry/prescriber notes as well as assessments and current treatment plans when such documentation exists. If these documents are not included with the referral form indicate when they will be available.

- Any section with an asterisk is required information.

**\*CONSUMER INFORMATION:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
 DOB: \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_ SS# \_\_\_\_\_  
 MA# \_\_\_\_\_ Medicare D Plan \_\_\_\_\_

**\*REASON FOR REFERRAL:**

\_\_\_\_\_  
\_\_\_\_\_

**\*DIAGNOSIS:**

ICD-10/DSM-5 Diagnosis \_\_\_\_\_  
 Diagnosing prescriber name \_\_\_\_\_

**REFERRAL SOURCE INFORMATION:**

Referring Party Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Indicate the best way for our staff to contact \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**CONSUMER SUPPORTS:**

Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

email: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Medical Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Payee/Money manager: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Partner/Family: \_\_\_\_\_ Phone: \_\_\_\_\_  
Other Key Contacts: \_\_\_\_\_ Phone: \_\_\_\_\_

Other services being received, or previously received:

Service: \_\_\_\_\_ Agency & Dates: \_\_\_\_\_  
Phone: \_\_\_\_\_ Address: \_\_\_\_\_  
Service: \_\_\_\_\_ Agency & Dates: \_\_\_\_\_  
Phone: \_\_\_\_\_ Address: \_\_\_\_\_

\*MEDICATIONS:

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PRESENTING ISSUES: Please comment on needs and strengths in the following areas.

Employment or Education:

Self-Care/ Activities of Daily Living:

Social/Interpersonal relationships:

General Medical and Dental:

Substance Abuse:

Legal:

Living Situation:

Financial:

Safety and Judgment:

Social Supports:

Other Information: